

Pennsylvania Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 390203	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 08/03/2023
NAME OF PROVIDER OR SUPPLIER: DOYLESTOWN HOSPITAL STATE LICENSE NUMBER: 300401		STREET ADDRESS, CITY, STATE, ZIP CODE: 595 WEST STATE STREET DOYLESTOWN, PA 18901			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
P 0000	<p>INITIAL COMMENT</p> <p>This report is the result of an unannounced revisit survey initiated on August 2, 2023, and completed on August 3, 2023, following a complaint investigation (CHL23C269V) initiated offsite on May 3, 2023, and completed offsite on May 12, 2023, at Doylestown Hospital. It was determined that the facility was in compliance with the requirements of the Pennsylvania Department of Health's Rules and Regulations for Hospitals, 28 PA Code, Part IV, Subparts A and B, November 1987, as amended June 1998.</p>	P 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:



Certified End Page

DOYLESTOWN HOSPITAL

STATE LICENSE NUMBER: 300401

SURVEY EXIT DATE: 08/03/2023

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY